VASCULAR LEGAL FORUM

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Legal ramifications of cancelling vascular surgical cases

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Elective vascular surgical procedures are occasionally canceled for unsuspected medical reasons, including low hemoglobin, low platelet count, urinary tract infection, or abnormal electrocardiogram. Oftentimes these patients are simply discharged from the hospital and told that the procedure will be rescheduled after they have been evaluated for the etiology of the abnormality. Furthermore, if they are inpatients, they may be told by the surgeon that their insurance will not permit the physician to keep them in the hospital. In many cases, no note concerning these matters is written in the chart by the attending physician. The case presented illustrates the potential legal ramifications of failure to appropriately address these issues.

Vascular surgeons occasionally choose to cancel treatment of a patient with an abdominal aortic aneurysm if the surgeon believes that the patient has not been optimized preoperatively. If the patient is an inpatient, can he/she be sent home, or must he/she remain in the hospital? Most times, patients do not suffer complications before elective surgery and, therefore, little emphasis is placed on developing specific time frames or discharging algorithms. However, if a patient does rupture his aneurysm before elective surgical treatment, litigation may well result.

In Johnson vs Botsford General Hospital, 278 Mich App. 146, 748 NW 2days 907, a 59-year-old man was seen by his vascular surgeon and scheduled for an elective resection of his abdominal aortic aneurysm on November 4, 2002. The patient presented to the hospital for preoperative testing the day before surgery and was found to have an abnormally low platelet count. The patient was admitted to the hospital for evaluation. The decedent expressed complete understanding for the need to cancel the surgery, but was upset about having to be in the hospital. The patient wanted to be discharged and continue his workup as an outpatient. The patient's son inquired as to whether or not it would be "safe" to send the patient home. The patient and family were advised by the vascular surgeon that the insurance would not pay for additional days in the hospital because they were not medically necessary. The physician went on to tell the patient that continued hospital stay "could potentially cost the patient thousands of dollars a day." The physician, however, did ask that someone from the hospital's administration verify the physician's interpretation of the patient's coverage. The hospital administrator told the patient and his family that there would be no insurance coverage if the patient stayed in the hospital. However, the family persisted. The administrator stated that she would call the insurance company, but the patient chose to leave the hospital before that call could be made.

The patient was followed by a hematologist as an outpatient and on November 12, 2002, the platelet count had increased and the patient was cleared for surgery by the hematologist. The patient ruptured his aneurysm on November 14, 2002, and died postoperatively.

The patient's family filed a medical malpractice/wrongful death law suit alleging that the patient was negligently discharged and that the hospital misinformed the patient about his insurance coverage. There was deposition testimony that it was malpractice to discharge a patient with a large aneurysm. In addition, it was alleged that the hospital was more concerned about economic issues than the care of this patient.

This case raises several important issues. First, physicians will often tell patients that the patient must be discharged because insurance will not cover continued hospitalization. This opinion is often unencumbered by any data. It is best for physicians to refrain from making such judgments. If the physician believes that a patient should be in the hospital for medical reasons, he/she should not discharge the patient for insurance reasons. If the physician believes that the patient can be discharged from a medical standpoint and the patient does not wish to be discharged, the hospital administration should assume the responsibility for informing the patient of the financial implications if

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the patient remains in the hospital. This is not the duty of the physician, and the physician should not assume this responsibility.

Furthermore, as demonstrated in this case, it is imperative that the physician thoroughly explain to the patient the reasons why a case is being canceled and, more importantly, the possible complications of cancelling the surgery. The risk/benefit ratio should be specifically addressed. Most importantly, the discussion should be clearly, carefully, and completely documented in the patient's chart. If a family member disagrees with the patient's decision to be discharged, this too should be documented. Finally, lack of insurance coverage or an attempt to decrease the cost of medical care is not a viable defense to a claim of negligent discharge. In Wickline vs State of California, 228 Cal. Rptr. 661, the court held:

> This court appreciates that what is at issue here is the effect of cost-containment programs upon the professional judgment of physicians to prescribe hospital treatment for patients requiring the same. While we recognize, realistically, that cost consciousness has become a permanent feature of the health care system, it is essential that cost limitation programs not be permitted to corrupt medical judgment.

The courts have repeatedly noted that physicians, not insurance companies, determine treatment. Decisions not to treat, or to limit treatment based upon cost, must be made by the patient, not the physician.

In conclusion, in Johnson vs Botsford Hospital, the court found that the plaintiff failed to properly state the claim against the hospital and the hospital was dismissed on summary judgment. The surgeon chose to settle.

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